**STATE OF MICHIGAN**

**DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**

**OFFICE OF FINANCIAL AND INSURANCE REGULATION**

**Before the Commissioner of Financial and Insurance Regulation**

**In the matter of**

**XXXXX**
**Petitioner**

**v** **File No. 121333-001-SF**

**Blue Cross Blue Shield of Michigan**
**Respondent**

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**Issued and entered**
**this _14th_ day of September 2011**
**by R. Kevin Clinton**
**Commissioner**

# ORDER

## I. PROCEDURAL BACKGROUND

On May 11, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006, MCL 550.1951 *et seq.* The Commissioner reviewed the request and accepted it on May 18, 2011.

The Petitioner is enrolled for health care coverage through XXXXX University, a self-funded local government group under Act 495. Respondent Blue Cross Blue Shield of Michigan (BCBSM) administers the plan. Section 2(2) of Act 495, MCL 550.1952(2), authorizes the Commissioner to conduct external reviews for individuals with this type of coverage in the same manner as reviews conducted under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on May 27, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is BCBSM's *Community Blue Group Benefits Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

## II. FACTUAL BACKGROUND

On November 9, 2010, the Petitioner had surgery to repair a hernia on his left side. The surgery was performed by XXXXX, MD, of XXXXX in XXXXX. Dr. XXXXX does not participate with either BCBSM or a local Blue Cross Blue Shield plan in XXXXX.

The Petitioner submitted a claim to BCBSM in the amount of $7,000 for the surgery and BCBSM paid him a total of $856.97. Dissatisfied with the amount paid, the Petitioner appealed BCBSM's decision through its internal grievance process. BCBSM held a managerial-level conference on April 20, 2011, and issued a final adverse determination dated April 25, 2011.

## III. ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's November 9, 2010, surgery?

## IV. ANALYSIS

Petitioner's Argument

The Petitioner had a second related surgical procedure in January 2011. The physician's charge for that surgery was $2,500 and BCBSM paid $1,000.[1] The Petitioner argues that both surgeries were very similar and therefore the claims should be processed as such. He believes that BCBSM should pay a higher percentage of the charge for the November 2010 surgery as it did for the January 2011 surgery. The Petitioner states the difference in cost between the two procedures is due to the fact that he directly negotiated a lower charge with the surgeon that performed the January 2011 surgery.

The Petitioner acknowledges the difference between participating and nonparticipating providers. He states that according to his contract, nonparticipating physicians are reimbursed at 80% of the approved rate. However, he states that BCBSM only paid 12.2% of the charge for the November 2010 surgery ($856.97 ÷ $7,000) as opposed to 40% for the January 2011 surgery ($1,000 ÷ $2,500).

The Petitioner also argues that it should not make a difference if a claim is submitted through the Blue Card Program (as for the January 2011 surgery) or directly to BCBSM (as was the case for the November 2010 surgery).

1 The Petitioner initially challenged BCBSM's payment amount for the January 2011 surgery but was able to resolve the claim directly with the surgeon. That claim is not part of this review.

The Petitioner believes BCBSM should be required to pay substantially more for his November 9, 2010, surgery.

BCBSM's Argument

BCBSM points out that the certificate (p. 4.2) provides that BCBSM's payment is based on an "approved amount" for a covered service. "Approved amount" is defined on p. 7.2 of the certificate: "The lower of the billed charge or [BCBSM's] maximum payment level for the covered service."

To determine its maximum payment level for each service, BCBSM applies a resource based relative value screen scale (RBRVS). This nationally recognized reimbursement structure was developed by and for physicians and reflects the resources required to perform each service, including physician time, specialty training, malpractice premiums, and practice overhead. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training and medical practice.

Using RBRVS, BCBSM determined that its maximum payment level for the November 2010 surgery was $856.97. It paid that to the Petitioner and does not believe it is required to pay any additional amount.

BCBSM also states that the claim for the January 2011 surgery was billed through the Blue Card program which meant that the out-of-Michigan Blue Cross Blue Shield plan determined the maximum payment level for the surgery. However, the claim for the November 2010 surgery was submitted directly to BCBSM by the Petitioner. Therefore, BCBSM's medical consultants determined the maximum payment level for this surgery by using procedure code 49520.

Commissioner's Review

Under the terms of the certificate, the Petitioner incurs the least out-of-pocket cost if he receives services from providers who participate with BCBSM (or with a Blue Cross or Blue Shield plan in another state). The certificate (p. 4.33) explains the possible consequences when services are received from nonparticipating providers:

> If the . . . provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM pays the same approved amount to both participating and nonparticipating providers. Participating providers have entered into an agreement with BCBSM to accept the approved amount as payment in full for covered services provided to BCBSM enrollees. However, nonparticipating providers have no contractual obligation to accept the approved amount as payment in full and may bill a BCBSM member for any balance over BCBSM's approved amount.

The certificate does not require a nonparticipating provider to be paid a greater amount than a participating provider. Moreover, as a nonparticipating provider, Dr. XXXXX is not bound to accept BCBSM's approved amount as payment in full and he may bill the Petitioner for any difference between his charge and BCBSM's approved amount.

The Petitioner argues that his two surgeries were very similar in nature and scope. This assertion seems to be borne out by the fact that BCBSM's approved amount for each was very similar: $1,000 for the January 2011 surgery and $856.97 for the November 2011 surgery. The fact that one surgeon charged a higher amount and the other agreed to not bill the Petitioner for any remaining balance does not require BCBSM to pay anything beyond its approved amount.

After reviewing the record, the Commissioner concludes that BCBSM covered the Petitioner's November 9, 2010, surgery correctly under the terms and conditions of the certificate. The amount paid for the November 9, 2010, surgery represents BCBSM's maximum payment level (and thus its approved amount) for that procedure.

## V. ORDER

BCBSM's final adverse determination of April 25, 2011, is upheld. BCBSM is not required to pay any additional amount for the Petitioner's November 9, 2010, surgery.

This is a final decision of an administrative agency. Under MCL 550.1915(1), any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner